Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 5, 13, 15, 2012	2012_140158_0022	Critical Incident

Licensee/Titulaire de permis

675412 ONTARIO INC
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

Long-Term Care Home/Foyer de soins de longue durée

NORTHVIEW NURSING HOME
77 RIVER ROAD, P.O. BOX 1139, ENGLEHART, ON, P0J-1H0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care (DOC), Registered staff, Personal Support Workers (PSW), and several residents.

During the course of the inspection, the inspector(s) reviewed a resident's health care record, reviewed the home's Fall Prevention and Management program and observed staff interaction and care with residents. Log # S-01997-11 and CI # 2585-000006-11 were reviewed during this Critical inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. Resident # 01, who was ambulating in the hall, tripped over the foot bars of the Sara Lift and sustained an injury. The resident was assessed by the Physiotherapist (PT) and was identified as a high risk to fall. The resident's progress notes identified that the resident had seven falls since August 2012. The health care record, including the plan of care was reviewed by the Inspector on November 5, 2012. Under transferring, an intervention; " assess resident's ability to transfer prior to each transfer" was documented. Under falls, interventions such as, " balance while standing; partial physical assist during test and assist with transfers and ambulating as required" is documented. Resident # 01 progress notes identified that on two occasions in October 2012, the use of a mechanical lift was used to transfer the resident. The licensee did not ensure that the written plan of care for resident # 01 set out, clear directions related to transferring to staff and others who provide direct care to the resident. [LTCHA 2007, S. O. 2007, c. 8, s. 6 (1)]
2. The health care record including the plan of care was reviewed by the Inspector on November 5, 2012. It is documented in resident # 01 progress notes that on four occasions , the resident was transferred into a geri - chair when the resident became tired from wandering and was unsteady on their feet. Staff # S-101 identified that a change in the resident's ability to follow direction and a change in the resident's thought process with Activities of Daily Living has occurred over the last 2-3 weeks and that the geri - chair has been used. Although the resident's plan of care identified interventions under falls, agitation and wandering, the use of a geri - chair is not one of the interventions identified. The licensee did not ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee did not ensure that when a resident has fallen, the resident is assessed and where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
Resident # 01, who was ambulating in the hall, tripped over the foot bars of the Sara Lift and sustained an injury. The home's Fall Prevention policy dated June 2010 was reviewed by the Inspector on November 5, 2012 and identified that "a post fall assessment is to be completed when the resident falls. Should the resident fall more than once in 24-hrs, only 1 assessment is completed".
The health care record, including the progress notes for resident # 01 were reviewed by the Inspector on November 5, 2012 and identified that the resident had seven falls since August 2012. No post fall assessments using a clinically appropriate assessment instrument that is specifically designed for falls were found in resident # 01 record. The Inspector spoke with Staff # 100 on November 7, 2012 who presented the Inspector with a form which they indicated was used to evaluate resident # 01 post fall. This form was devoid of a date and identified that the resident wanders at night. There was no mention that a fall had occurred. Staff # S-100 also stated that the home's Fall Prevention Policy was new and that the post fall assessment form which was not the same form presented previously was a new directive from corporate. [O. Reg. 79/10, s. 49 (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that when a resident has fallen, the resident is assessed and where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 15th day of November, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs